

I CONSENT (AGREE) TO MEDICAL SERVICES: I, the undersigned, hereby agree and consent to the plan of care proposed to me by the service practitioner to whom I have been referred. I will ask for any information I want to have about my services and will make my wishes known to the practitioners and/or staff. I understand that First Hill Diagnostic Imaging, also known as Swedish/First Hill Imaging, LLC, is a joint venture of Swedish Health Services and Imaging Services, Inc.

IN CASE OF AN EMERGENCY I WILL BE TREATED, INCLUDING CARDIOPULMONARY RESUSCITATION (CPR) UNLESS I REFUSE: This is to inform you of First Hill Diagnostic Imaging's (FHDI) policy in the event you should have an unexpected medical emergency. Our policy is to call 911 for medical assistance.

FHDI IS NOT RESPONSIBLE FOR MY PERSONAL VALUABLES: FHDI shall not be liable for the loss or damage to any money or articles of value such as eye glasses, watches and jewelry.

FHDI MAY GIVE INFORMATION TO MY HEALTH INSURANCE COMPANY FOR PAYMENT: FHDI to the extent required to assure payment, will disclose any diagnosis and pertinent medical information to a designated person, corporation, governmental agency or third party payor which is liable to FHDI for charges or who may be responsible for determining the necessity, appropriateness, or amount related to FHDI services or charges, including medical service companies, insurance companies, workmen's compensation carriers, Social Security Administration, intermediaries, carriers, and the State Department of Health and Human Services when the patient is a Medicaid or Medicare recipient. I understand that this disclosure, unless expressly limited by me in writing will extend to all aspects of my medical care including testing and or treatment for HIV/AIDS, sexually transmitted diseases, substance abuse, or mental health conditions.

IT IS MY RESPONSIBILITY TO PAY MY BILL OR TO MAKE ARRANGEMENTS TO HAVE MY BILL PAID:

Private Pay: The undersigned agrees, whether signing as agent or as a patient, to be financially responsible to FHDI for charges not paid by insurance. I understand this amount is due upon billing.

Insurance Coverage: I certify that the information given to me in applying for payment under government or private insurance is correct. I hereby assign payment directly to First Hill Diagnostic Imaging for benefits otherwise payable to me. Any portion of charges not paid by the insurance company will be billed to me and is then due and payable upon billing. I understand FHDI may verify my insurance coverage but that this does not guarantee payment by the insurance company and I will be responsible for all non-covered charges. I understand that it is my sole responsibility to determine the coverage limits of my insurance.

Financial Assistance: FHDI offers financial assistance for services that are provided in FHDI. Information and applications are available to you prior to or at any point during your service or after you have received a bill from us. Please contact a registration representative for further details.

I HAVE RECEIVED THE NOTICE OF HEALTH INFORMATION PRACTICES: I have received a copy of FHDI's Notice of Health Information Practices, which provides information about how my health information may be used and disclosed. I have read the above and understand its contents.

I have read the above and understand its contents.

Date: _____

Patient Signature: _____

Patient's Agent or Representative Signature: _____

Relationship to Patient: _____

PATIENT LABEL/TECH NOTES

FIRST HILL DIAGNOSTIC IMAGING
A Swedish Medical Imaging Center

Form 71004 Nonstock Rev. 4/09 CC

CONSENT FOR MEDICAL SERVICES

PATIENT REGISTRATION

PLEASE PRINT

Next Appointment with your doctor: Date: _____ Time: _____ : am/pm	Referring Doctor Name (last, first): _____
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PATIENT	Name: _____ Home Address: _____
	Sex: <input type="checkbox"/> M <input type="checkbox"/> F Marital Status: S___ M___ D___ W___ (City/State: _____ Zip: _____)
	Date of Birth: ____ / ____ / ____ SS#: - _____ Phone: (____) _____ Country: _____

EMPLOYER	Company: _____	EMERGENCY	Name: _____
	Address: _____		Address: _____
	City/State: _____ Zip: _____		City/State: _____ Zip: _____
	Work Phone: (____) _____		Phone: (____) _____
	Occupation: _____ <input type="checkbox"/> FT <input type="checkbox"/> PT Stu		Relation to Patient: _____

PERSON RESPONSIBLE FOR BILL	Patient's Relationship to Guarantor: _____	Employer: _____
	Name: _____	Address: _____
	Address: _____	City/State: _____ Zip: _____
	City/State: _____ Zip: _____	Work Phone: (____) _____
	Home Phone: (____) _____	Occupation: _____

PRIMARY INSURANCE	<i>Please provide copy of insurance card</i>	
	Name of insurance company: _____	ID/Certificate #: _____
	Address: _____	Policy/Group #: _____
	City/State: _____ Zip: _____	Group Name: _____
	Patient's Relationship to Subscriber: _____	Authorization #: _____
	Subscriber Last: _____ First: _____	M.I Birth Date: ____ / ____ / ____ SS#: - -

SECONDARY INSURANCE	<i>Please provide copy of insurance card</i>	
	Name of insurance company: _____	ID/Certificate #: _____
	Address: _____	Policy/Group #: _____
	City/State: _____ Zip: _____	Group Name: _____
	Patient's Relationship to Subscriber: _____	Authorization #: _____
	Subscriber Last: _____ First _____	M.I Birth Date: ____ / ____ / ____ SS#: - -

INJURY	Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	ATTORNEY	Is an attorney involved? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Work related? <input type="checkbox"/> Yes <input type="checkbox"/> No		Attorney name: _____ Phone: (____) _____
	Auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Address: _____
	Injury date: ____ / ____ / ____		City/State: _____ Zip: _____

As patient or legal guardian of patient, I agree to pay for all services rendered within 30 days of service in accordance with the financial policy of this office. I understand that this office bills insurance as a courtesy and that payment of the charges is my responsibility. I authorize my insurance benefits to be paid directly to the doctor & authorize the doctor or my insurance company to release any required information on this claim.

SIGNED: _____ DATE: _____

FIRST HILL DIAGNOSTIC IMAGING

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US/MR BREAST QUESTIONNAIRE

Your name: _____ Birth date: ____/____/____

Your primary physician: _____ Surgeon: _____

Reason for exam:

- KNOWN BREAST CANCER RIGHT LEFT
- NIPPLE DISCHARGE RIGHT LEFT
- BREAST LUMP RIGHT LEFT
- IMPLANTS SILICONE SALINE
- PERSONAL HISTORY OF BREAST CANCER
- HIGH RISK/FAMILY HISTORY
- ENLARGED LYMPH GLANDS UNDER ARM
- OTHER: _____

Previous mammogram:

YES NO DATE: _____ WHERE?: _____

Previous breast surgery? Yes No

RIGHT: Benign Malignant DATE: ____/____/____
MO. YEAR

LEFT: Benign Malignant DATE: ____/____/____
MO. YEAR

Previous breast biopsies? Yes No **NEEDLE ?:** _____ **SURGICAL?:** _____

RIGHT LEFT DATE: ____/____/____
MO. YEAR

Are you breast feeding? Yes No

Are you having menstrual periods? Yes No

If yes, first day of last menstrual period ____/____/____

Usual # of days from one period to the next _____

Have you taken birth control pills, hormone replacement therapy, naturopathic or bioidentical hormones in the last six months? Yes No

If yes, are you presently taking them? Yes No

If no, when did you discontinue use? ____/____/____

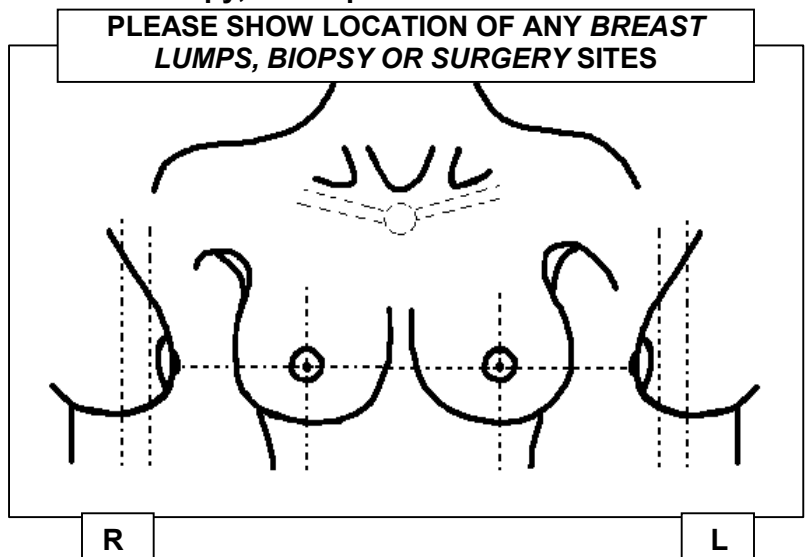
Family history of breast cancer?

**if you know, please note age at diagnosis*

- MOTHER/AGE: _____
- AUNT/AGE: _____
- SISTER/AGE: _____
- GRANDMOTHER/AGE: _____

Next appointment with your physician or surgeon?

_____/_____/_____



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